Virginia Department of Behavioral Health & Developmental Services

Community Care Request For Services Form

TABLE OF CODES WITH NARRATIVE:

DBHDS now requires any Medicaid Provider submitting Service Authorization using their National Provider Identifier (NPI) or Atypical Provider Identifier (API) to provide their 9-digit zip code. If you do not know your 9-digit zip code, then please visit: http://zip4.usps.com/zip4/welcome.jsp. Please see instructions per service type				
Fax: 1-804-225-3390			**Phone 1-804-663-7290**	
1. ☐ New Request	**☐ Change SRV Auth#**	**☐ Cancel SRV Auth#**	**☐ Transfer**	
2. Date of Request	**3. Review Type: (Please Check One)**			
(mm/dd/yyyy)	**☐ Waiver Enrollment**			
/ /	**☐ Waiver Enrollment-Retrospective Review (date Notified of Eligibility) / /**			
	☐ Service Request-If a Retrospective Review (Date Notified of Eligibility) / /			
4. Member Medicaid Id Number:	**5. Member Last Name**	**6. Member First Name**	**7. ☐ Date of Birth**	**8. Gender**
ID Number (12 digits)			**(mm/dd/yyyy)**	**☐ Male**
				☐ Female
9.		**10. Primary Diagnosis Code/Description:**		
a. Service Provider Name		**a.**		
b. NPI/API Provider ID Number:		**b.**		
c. 9 digit zip code: (required)		**c.**		
11.		**12. SRV AUTH Service Type:**		
a. NPI/API Submitting Provider/Case Manager for DD Waiver		**☐ 0902 – DD Waiver**	**☐ 0909-MFP**	
b. 9 Digit Zip Code (required)				
13. Justification/Need for Waiver Service Requested:				
14. Additional Comments (See instructions pertaining to each procedure code):				

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Member Last Name:		**Member First Name:**				**Member Medicaid ID Number:**		
15. Procedure Code (National Code):	**Narrative Description:**	**17. Modifiers (If Applicable)**	**18. Units/Hours Requested**	**19. Frequency**	**20. Actual Cost per Unit (if applicable)l**	**21. Total Dollar Requested (if applicable)**	**22. Dates of Service**	
							From (mm/dd/yyyy)	**Through (mm/dd/yyyy)**
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
							/ /	/ /
23. Contact Person:		**24. Contact Phone Number:**				**25. Contact Fax Number:**		

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TABLE OF CODES WITH NARRATIVE:
INSTRUCTIONS FOR WAIVER FAX FORM

Web Resources: http://dbhds.virginia.gov

This FAX submission form is required for Waiver enrollment and service requests for Service Authorization (SRV AUTH) review.
SRV AUTH request may be submitted via FAX, U.S. Mail.

Please be certain that all information blocks contain the requested information. Incomplete information may result in the case being rejected or returned via FAX for additional information.

If DBHDS determines that this request meets appropriate review guidelines the request will be "approved." Final approval is contingent upon passing remaining Member and Provider eligibility/enrollment edits. The Service Authorization (SRV AUTH) number provided by the DBHDS Fiscal Agent will be sent to you through the normal letter notification process and will be available via the Case Management Status Report within 24 hours (or the next business day).

1. Request type: Place a ✓or X in the appropriate box.
    - New: Use for all new requests. Resubmitting a request after receiving a reject is also considered a new request.
    - Change: Use to make a change to a previously approved request; the provider may change the quantity of units, dollar among approved, or dates of service due to changes in delivery or rescheduling and appointment. If additional units are requested for the same dates of service, enter the total number of units needed and not the increased amount. Any change request for increased services must include appropriate justification, including information regarding new physician orders when required. When a provider discontinues services, this is submitted as a change. The provider may not submit a "change" request for any item that has been denied or is pended. Include the SRV AUTH number you wish to change.
    - Cancel: Use only to cancel all or some of the items under one service authorization number. Do not use for a discharge or discontinuance of services. An example of canceling all lines is when an authorization is requested under the worn Member or Provider number. Include the SRV AUTH number to be cancelled.
    - Transfer: Use for requesting a transfer of care or transfer of a provider number.
2. Date of Request: Request in MM/DD/YYYY format.
3. Review Type: Place a ✓ or X in the appropriate box. For retrospective eligibility or if the request is not submitted within 10 business days of the Start of Care, state the date the Provider received verification of Medicaid Eligibility (DMAS-225). The date the DMAS-225 is received is not required unless submitting a request more than 10 business days after the Start of Care and retroactive authorization is requested.

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TABLE OF CODES WITH NARRATIVE:

4. Member Medicaid ID Number: It is the Provider's responsibility to ensure the Member's Medicaid number is valid prior to initiating this request. This is a 12 digit number.

5. Member Last Name: Enter the Member's last name exactly as it appears on the Medicaid card.

6. Member First Name: Enter the Member's first name exactly as it appears on the Medicaid card.

7. Date of Birth: Must be in the MM/DD/YYYY format (for example, 03/01/2016).

8. Gender: Please place a ✓ or X to indicate the gender of the Member.

9. a. NPI/API service provider Name and Provider ID Number: Enter the name of the Provider who is providing the service and Provider ID Number or National Provider Identifier (when the NPI is issued).
   b. 9 Digit Zip Code (Required): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.

10. Primary Diagnosis Code/Description: This is a required field. Provide the primary diagnosis code and/or description indicating the reason for service(s). You can enter up to 5 ICD-10 codes and/or diagnostic descriptions.

11. a. NPI/API Submitting Provider/Case Manager: Enter the submitting Provider name and Provider ID number, National Provider Identifier or Atypical Provider Identifier for the Provider submitting the request.
    b. 9 Digit Zip Code (Required): Providers must enter their 9 digit zip code to ensure their correct location is identified for the NPI number being submitted.

12. SRV AUTH Service Type: Place a ✓ or X to indicate the category of service being requested.

13. Justification/Need for Requested Waiver Service: Knowledge of the DMAS criteria/guidelines are required to provide pertinent information. Refer to the service being requested and include the necessary information.

14. Additional Comments: Used for further information and other considerations and circumstances to justify the request for medical necessity or the number of services. Describe expected prognosis or functional outcome. List additional information for each item to meet the criteria in the regulations, DMAS manual, and criteria (See Chapter IV and SRV AUTH Appendices in the DMAS manual).

TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
97139	Therapeutic Consultation: Justification/Need must include name of at least one other qualifying service currently authorized under the Waiver. Justification/Need may NOT include direct therapy, nor duplicate activities available through the State Plan. Justification/Need cannot be solely for the purpose of monitoring. • Service must be approved on the DMAS DD POC	DD
97537	Day Support, Regular, Center or Non-Center Based: • Service must be approved on the DMAS DD POC	DD
97537	**Day Support, Regular, Center or Non-Center Based:** • Service must be approved on the DMAS DD POC.	DD
97537 U1	**Day Support – High Intensity Center or Non-Center Based:** • Service must be approved on the DMAS DD POC.	DD
H0040	**Crisis Stabilization – Supervision:** Justification/Need must include name of at least one other qualifying service currently authorized under the Waiver. • Service must be approved on the DMAS DD POC. • There is a 15 day limit per authorization.	DD
H2011	**Crisis Stabilization- Intervention:** See code H0040 of this table. Must be approved on DMAS POC under 0902. • Service must be approved on the DMAS DD POC.	DD
H2014	**In-home Residential Support:** Justification/Need must include documentation of the name of the In-Home Residential Support direct care staff and the relationship to the Member. This is not the name of Provider agency. • Service must be approved on the DMAS DD POC.	DD
H2021 TD	**PERS Nursing –** **RN: DD** **Waiver:** Justification/Need must include documentation that the Member is authorized for PERS and medication monitoring (S5185). Justification/ Need must include documentation of the physician name and date for the physician ordered medication monitoring units and the name of at least one other qualifying Waiver service being provided. • Service must be approved on DMAS DD POC.	DD
National Code /Modifier	**Service Category/Description**	**Waiver**

TABLE OF CODES WITH NARRATIVE:

H2021 TE	**PERS Nursing –** **LPN: DD** **Waiver:** Justification/Need must include documentation that the Member is authorized for PERS and medication monitoring (S5185). Justification/ Need must include documentation of the name and date of the physician ordered medication monitoring units and the name of at least one other qualifying Waiver service being provided. • Service must be approved on DMAS DD POC.	DD
H2023	**Supported Employment-Individual:** Individual Supported Employment: Provided by a one to one job coach in order to work independently. • Service must be approved on the DMAS DD POC. **NOTE: This service, either as a standalone service or in combination with Prevocational and or Day Support services shall be limited to 2080 units per POC year.**	DD
H2024	**Supported Employment – Enclave (Group): Continuous support provided by staff to eight or fewer individuals in an enclave, work crew or bench/ entrepreneurial model.** • Service must be authorized on DMAS DD POC. **NOTE: This service, either as a standalone service or in combination with Prevocational and or Day Support services shall be limited to 780 units per POC year.**	DD
H2025	**Pre-Vocational Services, Regular Intensity:** Justification/ Need must include documentation of the date, type of services rendered and the number of hours and units provided per week. • Service must be authorized on DMAS DD POC. **NOTE- This service, either as a stand- alone service or in combination with Supported Employment services shall be limited to 780 units per POC year.**	DD
H2025 U1	**Pre-Vocational Services, High Intensity** See Code H2025 in this table.	DD
S5111	**Family Caregiver Training:** Justification/ Need must include the name and title of the professional providing the training. Justification/ Need must include documentation of the name of at least one other qualifying IFDDS Waiver service and the name of the individual being trained and the relationship to the Member. • Service must be approved on DMAS DD POC.	DD

TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
S5126	**CD Personal Care CD/Personal Assistance:** **DD Waiver** Justification/Need must include documentation of the name of the attendant and the relationship to the Member; as well as the name of the individual directing the care. • Service must be approved on the DMAS DD POC. For readmissions post discharge or transfer to a new Provider: A new assessment (DMAS 99) must be included in the documentation. If there is an increase or decrease in the amount of hours from the previous authorization/Provider, information from a new Plan of Care (DMAS 97 A/B) and justification for the change in hours is required for review.	DD
	NOTE: Training is not PC services. **NOTE: All waivers-aides may not be parents of minor children who are receiving Waiver services or the spouse of the individuals who are receiving Waiver services or the family/caregivers that are directing the individual's care.**	
S5135	**Companion Care (CC):** **NOTE: CC is not authorized for persons whose only need for CC is for assistance exiting the home in the event of an emergency and/ or socialization. CC is limited to 2080 hours per POC year for both types of CC combined.** • Service must be approved on the DMAS DD POC.	DD
S5136	**CD-Companion Care:** See code S5135 in this table above. • Service must be approved on the DMAS DD POC.	DD
S5150	**Consumer-Directed Respite Services:** **DD Waiver:** For readmissions after discharge or transfer to a new provider: A new assessment (DMAS 99) must be included in the documentation. • Service must be approved on the DMAS DD POC. Justification/Need must include the name of the unpaid PCG, the name of the individual directing the care and name of paid attendant.	DD

TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
S5160	**PERS Installation:** **DD Waiver:** Must be requested with S5161. For DD only: Service must be approved on the DMAS DD POC. Justification/Need must include name of at least one qualifying service currently authorized under the Waiver. • Service must be approved on the DMAS DD POC.	DD
S5160 U1	**PERS Medication Monitoring Installation:** Must be requested with S5185. • See S5160 in this table above. • For DD only: Service must be approved on the DMAS DD POC.	DD
S5161	**PERS Monitoring:** **DD Waiver:** If submitted without PERS install, there must be PERS install authorization in place or documentation must include verification that member has PERS unit in place (e.g. through private pay). Justification/Need must include name of at least one qualifying service currently authorized under the Waiver. • Service must be approved on the DMAS DD POC. **DD Waiver:** Must be requested with S5161. Justification/Need must include name of at least one qualifying service currently authorized under the waiver. • Service must be approved on the DMAS DD POC.	DD
S5165	**Environmental Modifications-** **DD Waiver**: Any request, change, increase, decrease and/or update must be pre-approved by DMAS on the POC before Service Authorization can occur. Justification/Need must include documentation of the name of at least one other qualifying Waiver service currently authorized under the Waiver and a description of the modification being requested. • Dates of service authorized can not crossover the DMAS POC year. **MFP Waiver:** Justification/Need must include documentation for the description of the item, cost of materials, labor and must describe the direct medical and/ or remedial benefit to the individual.	DD

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National Code /Modifier	Service Category/Description	Waiver
99199 U4	**Environmental Modifications – Maintenance: Used when request is for maintenance to a previous approved and purchased item.** • Service must be approved on the DMAS DD POC. See code S5165 in this table.	DD
S5185	**PERS and Medication Monitoring:** See Code H2021TE and H2021TD in this table.	DD
S9125TE	**Respite Services – LPN:** See code S9125TD in this table.	DD
T1002	**Private Duty/Skilled Nursing-RN:** **DD Waiver**: • Service must be approved on DMAS DD POC • Service may be authorized for up to 6 months per request in accordance with the date range covered by the CMS 485 and DMAS DD POC. • .Justification/Need must include date of physician's signature on the CMS 485 and the effective start of care date of the physician's order/CMS 485.	DD
T1003	**Private Duty/Skilled Nursing-LPN:** See Code T1002 in this table.	DD
T1005	**Agency Respite Care/Services:** **DD Waiver:** Justification/Need must include the name of attendant and relationship to the Member. • Service must be approved on DMAS DD POC. For readmissions after discharge or transfer to a new provider: A new assessment (DMAS 99) must be included in the documentation. Justification/Need must include documentation of the name of the **unpaid** PCG and the name of the paid attendant.	DD
T1019	**Personal Care:** **DD Waiver**: Justification/Need must include documentation of name of the attendant and relationship to the Member. • Service must be approved on DMAS DD POC. For readmissions post discharge or transfer to a new Provider: A new assessment (DMAS 99) must be included in the documentation. If there is an increase or decrease in the amount of hours from the previous authorization/Provider, information from a new Plan of Care (DMAS 97 A/B) and justification for the change in hours is required for review. **NOTE: Training is not PC services.**	DD

TABLE OF CODES WITH NARRATIVE:

National Code /Modifier	Service Category/Description	Waiver
T1999	**Assistive Technology Rehabilitation/ Off shelf item: DD Waiver:** **Any request, change, increase, decrease and /or update must be pre-approved by DMAS on the POC before Service Authorization can occur.** Justification/Need must include documentation of the name of the item and total cost, which is not carried over from one POC year to another POC year. • Date of service authorized cannot crossover the DMAS DD POC year. **MFP:** Justification/Need must include documentation item must be from a qualified professional and include the description of the item, cost of materials, labor and must provide direct medical benefit to the individual.	DD
T1999 U5	**Assistive Technology Maintenance Cost: Used when request is for maintenance to a previous approved and purchased item.** See code T1999 in this table.	DD
T2038	**Transition Services.** The Transition Coordinator or Case Manager must submit the request for Transition Services. Prior to and after discharge from the facility**, Transition Services may be requested for individuals transitioning into EDCD Waiver.** DMAS processes DD Waiver requests for Transition Services prior to and after discharge. Requests for Transition Services must be submitted within 30 days of the NF/Long-Stay Hospital discharge date. **Member must be enrolled in MFP or the specific Waiver and have been a resident of an NF for 6 months prior to Waiver enrollment.**	DD

15. **Procedure Code:** Provide the HCPCS/CPT/Revenue/National procedure code (For example, T1019, S5135, etc.)
16. **Narrative Description:** Provide the HCPCS/CPT/Revenue/National procedure code description. (For example, Personal Care, Companion Care, etc.)
17. **Modifiers (if applicable):** Enter up to 4 modifiers as applicable. This applies only to specific Procedure Codes. See chart above. Example: Pre-Vocational Services, High Intensity, U1 is the modifier.
18. **Units/Hours Requested**: Based on physician's orders or Plan of Care provide the number of units/hours requested. Knowledge of DMAS criteria will be extremely helpful. How much of the service is being requested? Example: S5126, CD Personal Care, 30 hours/ week. The 30 hours is the Units/hours requested.
19. **Actual Cost per Unit (Assistive Technology or Environmental Mods Only)**: Enter information in this column for codes identified as needing a cost per unit. For AT, actual cost reflects wholesale cost.
20. **Frequency**: Enter the frequency of the visits/service from the physician's order or Plan of Care. (day, week, biweekly {every other week}, month, year)
21. **Total Dollars Requested (Assistive Technology and Environmental Mods, Only)**: If applicable, enter the dollar amount requested for items listed. All AT/EM codes combined cannot exceed $5,000.00 in a calendar year. For AT, Wholesale cost will be reimbursed at the cost x 30%.
22. **Dates of Service**: Indicate the planned service dates using the MM/DD/YYYY format. The From and

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Thru date must be completed even if they are the same date.

23. **Contact Name**: Enter the name of the person to contact if there are any questions regarding this fax form.
24. **Contact Phone Number:** Enter the phone number with area code of the Provider contact name.
25. **Contact Fax Number:** Enter the fax number with the area code to respond if there is a denial/reject, a need to request additional information, insufficient (demographic) information, or to send a General Provider Letter via fax.

Note: Incomplete data may result in the request being rejected or denied; therefore, it is very important that this form be completed as thoroughly as possible with the pertinent information.

The purpose of Service Authorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Service Authorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process, the Member's continued Medicaid eligibility, and the ongoing medical necessity for the service being provided.

There are no automatic renewals of services and you must request service authorization before the current authorization ends to avoid any breaks in services.